No. 19-4060

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JEFFREY D. MANN, et al.,	:	
Plaintiffs-Appellants,	:	On Appeal from the
	:	United States District Court
v.	:	for the Southern District of Ohio,
	:	Eastern Division
OHIO DEPARTMENT OF	:	
REHABILITATION AND CORRECTION, et	:	District Court Case No.
al.,	:	2:18-cv-01565
Defendants-Appellees.	:	
	:	

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

STATEMENT REGARDING ORAL ARGUMENT viii

JURISDICTIONAL STATEMENT 1

STATEMENT OF THE ISSUES 2

INTRODUCTION 3

STATEMENT OF THE CASE 5

SUMMARY OF ARGUMENT 14

STANDARD OF REVIEW 18

ARGUMENT 19

I. This Court should affirm the judgment of the District Court. 19

A. The District Court properly held that the inmates failed to allege a deliberate-indifference claim. 20

B. Even if the Court declines to affirm the District Court in all respects, it should affirm in part under the qualified-immunity doctrine and the bar on *respondeat superior* claims. 30

1. At minimum, the Court should affirm the District Court's dismissal of the damages claims because those claims fail under the qualified-immunity doctrine. 31

2. The District Court correctly dismissed the inmates' claims against Grafton's healthcare administrator because those claims seek relief under a *respondeat superior* theory. 35

II. The inmates do not offer a sound reason for overturning the judgment of the District Court. 38

A. The inmates did not allege a facially plausible deliberate-indifference claim. 39

1. The inmates did not allege that the officers altogether denied them treatment for hepatitis C. 39

2. The Department's treatment protocols were not "blanket policies" that failed to consider individual circumstances. 46

3. The officers did not delay providing antiviral medication to the inmates for non-medical reasons. 49

B. The District Court properly dismissed the claims against the Grafton healthcare administrator 52

CONCLUSION 53

CERTIFICATE OF COMPLIANCE 54

CERTIFICATE OF SERVICE 55

DESIGNATION OF DISTRICT COURT RECORD 56

TABLE OF AUTHORITIES

Cases **Page(s)**

Abu-Jamal v. Wetzel,
No. 3:16-CV-2000, 2017 U.S. Dist. LEXIS 368 (M.D. Pa. Jan. 3, 2017) 44, 45

Allah v. Thomas,
679 F. App'x 216 (3d Cir. 2017) (*per curiam*) 51

Alspaugh v. McConnell,
643 F.3d 162 (6th Cir. 2011) 15, 16, 22, 26

Angel v. Kentucky,
314 F.3d 262 (6th Cir. 2002) 34

Ashcroft v. al-Kidd,
563 U.S. 731 (2011) 17, 31, 32

Ashcroft v. Iqbal,
556 U.S. 662 (2009) 2, 18, 29

Bartlett v. Michigan,
No. 17-2274, 2018 U.S. App. LEXIS 12221 (6th Cir. May 9, 2018) 19

Bash v. Textron Fin. Corp. (In re Fair Fin. Co.),
834 F.3d 651 (6th Cir. 2016) 19

Bass v. Robinson,
167 F.3d 1041 (6th Cir. 1999) 36

Black v. Alabama Department of Corrections,
578 F. App'x 794 (11th Cir. 2014) 27, 28, 42

Blackmore v. Kalamazoo Cty.,
390 F.3d 890 (6th Cir. 2004) 14, 21

Buchanon v. Mohr,
No. 2:16-cv-279, 2016 U.S. Dist. LEXIS 121432 (S.D. Ohio Sep. 8, 2016) 42

City & Cty. of S.F. v. Sheehan,
135 S. Ct. 1765 (2015) 32

City of Escondido v. Emmons,
139 S. Ct. 500 (2019) 31, 32

Colwell v. Bannister,
763 F.3d 1060 (9th Cir. 2014) 47, 48

Comstock v. McCrary,
273 F.3d 693 (6th Cir. 2001) 22, 23, 29

Cook v. Corizon Health, Inc.,
No. 19-1660, 2020 U.S. App. LEXIS 5006 (6th Cir. Feb. 18, 2020) 33, 42

Darrah v. Krisher,
865 F.3d 361 (6th Cir. 2017) 49

Dawson v. Archambeau,
763 F. App'x 667 (10th Cir. 2019) 42

De'Lonta v. Angelone,
330 F.3d 630 (4th Cir. 2003) 47

Edmonds v. Robbins,
67 F. App'x 872 (6th Cir. 2003) 33, 42

Estelle v. Gamble,
429 U.S. 97 (1976) 3

Fears v. Morgan (In re Ohio Execution Protocol),
860 F.3d 881 (6th Cir. 2017) 34, 35

Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.,
537 F.3d 667 (D.C. Cir. 2008) 24

French v. Daviess Cty.,
376 F. App'x 519 (6th Cir. 2010) 48

Goodman v. Kimbrough,
718 F.3d 1325 (11th Cir. 2013) 18, 52

Gordon v. Schilling,
937 F.3d 348 (4th Cir. 2019) 42, 43

Graham v. Cty. of Washtenaw,
358 F.3d 377 (6th Cir. 2004) 14, 22

Harris v. Klare,
902 F.3d 630 (6th Cir. 2018) 33

Helling v. McKinney,
509 U.S. 25 (1993) 24

Hix v. Tennessee Dep't of Corr.,
196 F. App'x 350 (6th Cir. 2006) 21, 33

Inge v. Rock Fin. Corp.,
281 F.3d 613 (6th Cir. 2002) 18

Jones v. City of Cincinnati,
521 F.3d 555 (6th Cir. 2008) 19

Jones v. Horne,
634 F.3d 588 (D.C. Cir. 2011) 18, 52

Kisela v. Hughes,
138 S. Ct. 1148 (2018) 31, 33

Lane v. City of Lafollette,
490 F.3d 410 (6th Cir. 2007) 18, 52

Lovelace v. Clarke,
No. 2:19cv75, 2019 U.S. Dist. LEXIS 133012 (E.D. Va. Aug. 7, 2019) 44, 45

Peatross v. City of Memphis,
818 F.3d 233 (6th Cir. 2016) 17, 36, 37

Phillips v. Roane Cty.,
534 F.3d 531 (6th Cir. 2008) 31

Postawko v. Mo. Dep't of Corr.,
No. 2:16-cv-04219-NKL, 2017 U.S. Dist. LEXIS 71715 (W.D. Mo. May 11, 2017) 44, 45

Rhinehart v. Scutt,
894 F.3d 721 (6th Cir. 2018) .... *passim*

Roe v. Elyea,
631 F.3d 843 (7th Cir. 2011) 48

Rouster v. Cty. of Saginaw,
749 F.3d 437 (6th Cir. 2014) 15, 16, 26

Roy v. Lawson,
739 F. App'x 266 (5th Cir. 2018) 26, 27, 42

Santiago v. Ringle,
734 F.3d 585 (6th Cir. 2013) 21

Saylor v. Williams,
No. 86-5469, 1986 U.S. App. LEXIS 33407 (6th Cir. Nov. 10, 1986) 18

Se. Tex. Inns, Inc. v. Prime Hosp. Corp.,
462 F.3d 666 (6th Cir. 2006) 19

Shehee v. Luttrell,
199 F.3d 295 (6th Cir. 1999) 37

Soudemire v. Mich. Dep't of Corr.,
705 F.3d 560 (6th Cir. 2013) 32

Terrance v. Northville Reg'l Psychiatric Hosp.,
286 F.3d 834 (6th Cir. 2001) 23, 26, 44, 47

Westlake v. Lucas,
537 F.2d 857 (6th Cir. 1976) .... *passim*

Wilkins v. Gaddy,
559 U.S. 34 (2010) 24

Williams v. Catoe,
No. 6:17cv627, 2018 U.S. Dist. LEXIS 229924 (E.D. Tex. Aug. 4, 2018)....................42

Winkler v. Madison Cty.,
893 F.3d 877 (6th Cir. 2018)....................2

Statutes

28 U.S.C. §1291....................1

28 U.S.C. §1331....................1

42 U.S.C. §1983....................*passim*

Other Authorities

Fed. R. Civ. P. 12....................4, 19, 20

Fed. R. Civ. P. 56....................19

STATEMENT REGARDING ORAL ARGUMENT

Because this case raises important constitutional issues, Defendants-Appellees request oral argument.

JURISDICTIONAL STATEMENT

The District Court had jurisdiction under 28 U.S.C. §1331. That court entered a final judgment on September 26, 2019. The appellants timely appealed on October 24, 2019, and this Court has jurisdiction under 28 U.S.C. §1291.

STATEMENT OF THE ISSUES

1. The Eighth Amendment prohibits prison officials from acting with deliberate indifference to prisoners' serious medical needs. Prison officials violate this prohibition only when they refuse to treat serious medical conditions, or when they treat such conditions using methods so "woefully inadequate" that they "amount to no treatment at all." *Westlake v. Lucas*, 537 F.2d 857, 860 n.5 (6th Cir. 1976); *see also Winkler v. Madison Cty.*, 893 F.3d 877, 892 (6th Cir. 2018). The plaintiff inmates in this case, all of whom had hepatitis C, alleged that the defendant prison officials enrolled them in a clinic to monitor their conditions and provide them antiviral medicine if the disease became sufficiently severe. Did they allege facts giving rise to a deliberate-indifference claim on which relief can be granted?

2. No precedent from this Court or the Supreme Court establishes beyond debate that prisoners with hepatitis C have a right to antiviral drugs without regard to the disease's stage. Are the prison-official defendants entitled to qualified immunity?

3. Plaintiffs may not seek relief under 42 U.S.C. §1983 under a *respondeat superior* theory. *Ashcroft v. Iqbal*, 556 U.S. 662, 676 (2009). The inmates' claims against one defendant officer sought to hold the officer liable based on the conduct of his subordinates. Did the District Court properly dismiss that claim?

INTRODUCTION

The Eighth Amendment forbids the government from imposing cruel and unusual punishments. This prohibition means that prison officials may not "unnecessar[ily] and wanton[ly] inflict[] pain" on inmates. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (quotations omitted). Officials can violate this rule by actively causing pain, but also by failing to alleviate it. For example, prison officials violate the Eighth Amendment when they act with deliberate indifference to a prisoner's serious medical needs. This case presents the question whether prison officials act with deliberate indifference whenever they administer treatments that are inconsistent with the standard of care applied outside of prison.

The three plaintiffs in this case—all of whom are inmates at the Grafton Correctional Institution—argue that the answer is yes. Each inmate has a "slowly progressive viral condition" called chronic hepatitis C. Grafton employees periodically evaluated and treated each inmate for the disease through various rounds of counseling, testing, and monitoring. But the inmates say that was not enough. According to them, the prison should have *immediately* treated them with antiviral medicine, also known as "antiviral therapy," that could *potentially* have cured their disease. Under the then-applicable prison protocols, prisoners whose diseases progressed enough would indeed receive antiviral therapy. But because the inmates'

diseases had not progressed far enough to qualify for such treatment, the prison denied the inmates' requests.

The inmates filed this lawsuit against the Ohio Department of Rehabilitation and Correction, several of its officers, and various other Ohio prison officials and employees. The inmates alleged that the defendants had been deliberately indifferent to their serious medical needs, in violation of the Eighth Amendment. How? By denying the inmates the treatment they wanted when they wanted it. They sued these officials—some in their personal capacities, some in their official capacities, and others in both capacities—under 42 U.S.C. §1983. The inmates sought monetary damages to the tune of $50 million. And they sought injunctive relief, too. In addition to seeking antiviral medication, the inmates wanted to be treated with a relatively new class of drugs that purportedly has a high cure rate and low side effects. The inmates also sought access to better diagnostic tools. Finally, they asked the court to order wholesale reform of the testing and treatment protocols that the Department's officers had carefully designed over a period of years. The District Court dismissed the inmates' claims for failure to state a claim upon which relief can be granted. *See* Fed. R. Civ. P. 12(b)(6).

This Court should affirm. The Eighth Amendment does not guarantee prisoners the treatments of their preference at the time of their preference. It *does*

guarantee them medical care. Even accepting as true all allegations in the complaint, the inmates received care—meaningful care—for hepatitis C. As a result, the inmates failed to allege a plausible deliberate-indifference claim.

STATEMENT OF THE CASE

1. "Hepatitis C is a slowly progressive viral condition" that affects the liver. R.6, Compl., Ex. L, PageID#371. It is transmitted through "contact with blood or blood products," often from "[s]haring intravenous needles" or "tattooing needles." *Id.*, PageID#372–73. "[I]n a limited number of patients," the disease "will cause long-term complications." *Id.*, PageID#371. The most common of these complications is progressive fibrosis (scarring), which can result in cirrhosis. *Id.*

15 to 25 percent of infected individuals naturally overcome the disease without any medication. *Id.*, PageID#372. Only a minority develop advanced liver disease, which can take "ten to twenty years or longer." *Id.*, PageID#371. Because hepatitis C is such a slowly progressing disease, and because a person can live with it for decades without symptoms, its treatment is not supposed to "take precedence over acute illness" or "receive priority over other medical conditions." *Id.*

Still, Ohio's Department of Rehabilitation and Correction has long taken hepatitis C very seriously. It provides immediate care to those who have the disease. *Id.*, PageID#371–72. In fact, under the treatment protocols to which the in-

mates in this suit object, the Department screened *all* new prisoners for hepatitis C upon their arrival at an Ohio prison. *Id.* The same protocols instructed officials to test for the disease "as medically necessary." *Id.,* PageID#372. If a prisoner tested positive for the disease, that prompted a course of treatment that involved counseling, evaluation, and—if appropriate—medication. *Id.*, PageID#372–73. (Because the protocols have been altered, *see below* 13, much of what follows is written in the past tense. But much of what follows also remains true under the new protocol.)

Through counseling, prisoners were educated about how the disease is transmitted. *Id.*, PageID#372. They learned that "[t]he natural course of the disease" is "highly variable and very prolonged, usually measured in decades." *Id.* And they learned about actions they could take to help stop the spread of the disease. *See id.*, PageID#373. In addition, prisoners were counseled about making healthy lifestyle changes. *See id.*, Ex. M, PageID#385. That counseling was important because certain lifestyle changes—like quitting alcohol and tobacco, losing weight, and staying active—can slow the disease's progression. *See id.*, Ex. N, PageID#412.

Ohio enrolled infected prisoners into a Chronic Care Clinic. *Id.*, Ex. L., PageID#373. The Clinic had three purposes. *First*, to correctly diagnose the cause of the prisoner's liver disease and develop an appropriate monitoring and treatment

plan. *Second*, to promote understanding of the cause, symptoms, and treatment of the inmate's disease. *Third*, through the Clinic, the prison would stress the importance of complying with the therapeutic regimen. *Id.*, Ex. M, PageID#381. A prisoner's enrollment in the Clinic marked the beginning of a recurring routine of evaluations, tests, and other forms of treatment that continued until the inmate was completely cleared of the disease. *See id.*, Ex. L., PageID#373–74.

Once in the Clinic, a prisoner's initial evaluation involved a complete medical history, physical assessment, and diagnostic testing. *Id.*, PageID#379. These assessments, in turn, consisted of several different types of examinations. *Id.* To take just a few examples, prisoners underwent cardiac, lung, skin, abdominal, and neurological exams. *Id*. They also took blood tests in order to calculate their Platelet Ratio Index (APRI) Score. *Id.* Generally, an APRI score of less than 0.5 indicates probable fibrosis; a score between 0.5 and 1.5 indicates mild to severe fibrosis; and a score above 1.5 indicates cirrhosis. *Id.*, Ex. K, Page ID#361. The Clinic also vaccinated inmates against other types of hepatitis. *Id.*, Ex. L, PageID#379. And the Clinic, at all times relevant to this suit, administered medication (non-selective beta blockers) to inmates with esophageal varices (swollen veins) or portal hypertension (high blood pressure in the portal vein). *Id.*

All prisoners who participated in the Clinic received a battery of examinations, vaccinations, and medication, all on an ongoing basis. *See id.*, Ex. L, PageID#380; Ex. M, PageID#385. The frequency of evaluations turned on the status of the prisoner's disease. Generally, if a prisoner's condition was improving and under "[g]ood control," he was evaluated every six to twelve months. *Id.* If his condition was stable and under "[f]air control," he was evaluated every three to six months. *Id.* And if his condition was worsening and under "[p]oor control," he was seen as often as necessary but at least once a month. *Id.* Moreover, clinicians could "elect to refer [inmates] to a nurse for an interim visit between regular chronic care visits for additional medication adherence[,] monitoring, counseling, patient education, or lab work monitoring." *Id.*

Prisoners were considered for antiviral medication (also known as "antiviral therapy") at each of these evaluations. *See id.*, Ex. L, PageID#379–80. To receive such medication, prisoners had to meet certain "[i]nclusion criteria." These criteria included (among other things): the patient's consent and commitment to abstain from alcohol and substance abuse; the approval of a mental-health examiner; a detectable hepatitis C viral load; a liver biopsy indicating significant fibrosis; and an APRI score of 1.5 or greater. *Id.*, PageID#375. Additionally, the protocols contained "[e]xclusion criteria" that, if satisfied, would take a prisoner out of consid-

eration for drugs. For example, inmates would be found ineligible for treatment based on a current or planned pregnancy, substance or alcohol abuse, documented non-adherence to previous therapy, or hypersensitivity to the drugs used. *Id.*, PageID#374.

With respect to qualifying prisoners, the Department developed an appropriate regimen and the inmate began receiving antivirals. *See id.*, PageID#376. A health professional continued to see the patient every week for four weeks, and then every four weeks after that for the duration of the therapy. *Id.*, PageID#377. After the patient completed the therapy, a health professional continued to evaluate him. *Id.* All patients showing no detectable viral load twelve months after the completion of therapy were deemed treatment successes. *Id.* Those who still had a detectable viral load at that time were deemed treatment failures, and would remain under the Clinic's evaluation. *Id.* Depending on his condition, a patient who qualified as a treatment failure could be eligible for additional medication. *See id.*, PageID#374–75, 377.

There is one important caveat to this summary of the Department's protocols: the protocols were neither used as "a substitute for [the] professional judgment [of] the attending physician," nor were they "used in the treatment of inmates with acute liver disease." *Id.*, PageID#370. They merely provided "guide-

lines for the evaluation and management" of the average inmate suffering from hepatitis C. *Id.* In other words, doctors could deviate from the protocols and provide antiviral therapy to a not-otherwise-qualifying inmate.

2. In 2018, three inmates at the Grafton Correctional Institute—Jeffrey D. Mann, John T. Bragg, and Eric Pastrano—filed this §1983 lawsuit. They sued the Department, along with numerous (named and unnamed) prison officials. R.6, Compl., PageID#239–40. For example, they sued Dr. Andrew Eddy, who chairs the Department's Collegial Review Committee and helps formulate all of the Department's medical policies and protocols. *Id.* ¶48, PageID#247. The inmates also sued Grafton's healthcare administrator and chief medical officer, along with "various unknown … health care providers" who provided medical care for Ohio prisoners. *Id.*¶¶10–12, PageID#242. Proceeding *pro se*, the inmates alleged that the Department's hepatitis C protocol constituted cruel and unusual punishment in violation of the Eighth Amendment. More precisely, they alleged that the officers acted with "deliberate indifference" to the inmates' "serious medical needs" in promulgating, interpreting, and applying the protocols. *Id.* ¶59, PageID#249.

Each inmate had hepatitis C. And each had been denied antiviral therapy, upon requesting it in 2018, because none qualified for it under the Department's treatment protocol. Mann and Bragg had APRI scores too low to qualify for antivi-

ral treatment. Both had been treated with Interferon and Ribovirin (two antiviral drugs) for forty-six weeks, but following partial remission, the virus returned. *Id.*, PageID#244–45. When Mann and Bragg requested antiviral treatment in 2018, their requests were denied because both had APRI scores below 1.5—Mann's score was 0.36 and Bragg's score was 0.5. *See id.*, Exs. R & S, PageID#422–423. Those APRI scores indicated that neither's condition had progressed to the later stages of the disease. Although Pastrano's APRI score is not in the record, he was denied antiviral drugs because he had "no signs of advanced disease." *Id.*, Ex. T, PageID#424. Importantly, all three inmates were enrolled in the Clinic when they filed their administrative grievances and this suit. *Id.*, Exs. R–T, PageID#422–425. So, other than some bloodwork that Pastrano claims he did not receive, the Department had long been monitoring and evaluating each inmate consistent with its treatment protocols. *Id.* Though all of this information appears in attachments to the inmates' complaint, the inmates insisted that the decision to deny them access to antiviral drugs was "based solely upon cost." *Id.* ¶45, PageID#246–47.

The inmates alleged that, by denying them antiviral medications, the defendant officials were acting with "deliberate indifference to the[ir] serious medical needs." *Id.* ¶59, PageID#249. They sought $50 million in damages. *Id.* ¶C. And they sought injunctive relief. *Id.* ¶¶A–B. In addition to seeking an order requiring

the prison to treat the inmates with antiviral medications, the inmates sought wholesale reform of the Department's treatment protocols. More precisely, they sought:

> (1) a declaration that the Department's treatment protocols "do not conform to the standards of care generally accepted in the medical community" and that they "deny adequate necessary medical care to the [inmates] and to all others similarly situated";

and

> (2) an injunction requiring the defendants "to immediately begin adequate, timely, effective and appropriate diagnostics and treatment generally accepted in the medical community for [hepatitis C] for the [inmates] and all others similarly situated."

Id.

After the inmates filed their complaint, the State of Ohio (as an interested party) and some of the other defendants moved to dismiss. R.15, MTD, PageID#454; R.20, MTD, PageID#483. The magistrate judge recommended granting in part and denying in part the motions to dismiss. R.45, R&R, PageID#632. But the District Court held that the motions to dismiss ought to be granted in full. R.52, Order, PageID#678–81. First, it held that the inmates' claims against the Department were barred by the Eleventh Amendment. *See id.*, PageID#681. Next, it held that the claims against Dr. Eddy and the Grafton healthcare administrator failed because they rested "on the theory of *respondeat superior*,"

which is not a valid theory of relief under §1983. *Id.*, PageID#679. Finally, the District Court dismissed the deliberate-indifference claims against the remaining defendants. It determined that the inmates had failed to allege facts that, taken as true, would show the defendants had "recklessly disregard[ed] a substantial risk to [the inmates'] health." *Id.*, PageID#680.

After the District Court issued its decision, the remaining defendants filed motions to dismiss. R.56, R&R, PageID#696. Each of those defendants had been accused of violating the Eighth Amendment through deliberate indifference to the inmates' medical needs. The magistrate judge found, and the District Court held, that the claims against these defendants failed for the reasons outlined in the District Court's earlier decision. *Id.*, PageID#700–01; R.58, Order, PageID#709. The District Court entered final judgment on September 26, 2019.

The inmates appealed. On appeal, they challenged the District Court's decision only with respect to the individual defendants. They did not appeal the ruling that the Department itself is immune from suit under the Eleventh Amendment.

3. Two important developments followed the filing of this appeal. First, the prison adopted a new protocol for treating hepatitis C. Second, between February 12 and February 25, all three inmates were approved to begin receiving treatment with Epclusa, which is one of the new antiviral drugs that the inmates had request-

ed. As of March 6, all three inmates were being treated with the drug. Although that does not moot the entire appeal—the inmates sought monetary damages, and the claim for those damages is still alive—it does moot their request for an injunction entitling them to this medication.

SUMMARY OF ARGUMENT

1. There are two components to a deliberate-indifference claim, one objective and the other subjective. The objective component requires the existence of a "'sufficiently serious' medical need." *Blackmore v. Kalamazoo Cty.*, 390 F.3d 890, 895 (6th Cir. 2004) (quoting *Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). The subjective component requires the officer to be *deliberately indifferent* to those needs. No one disputes that the inmates have sufficiently serious medical needs. This case is about whether the inmates adequately alleged that the officers were deliberately indifferent to those needs. They did not.

"Where a prisoner has received *some* medical attention and the dispute is over the *adequacy* of the treatment," the Court is "generally reluctant to second guess medical judgments and to constitutionalize claims which sound in state tort law." *Westlake v. Lucas*, 537 F.2d 857, 860 n.5 (6th Cir. 1976) (emphasis added); *accord Graham v. Cty. of Washtenaw*, 358 F.3d 377, 385 (6th Cir. 2004). The Court therefore "distinguish[es] between cases where the complaint alleges a complete

denial of medical care and those cases where the claim is that a prisoner received *inadequate* medical treatment." *Westlake*, 537 F.2d at 860 n.5 (emphasis added); *accord Rhinehart v. Scutt*, 894 F.3d 721, 740 (6th Cir. 2018); *Alspaugh v. McConnell*, 643 F.3d 162, 169 (6th Cir. 2011). Claims alleging inadequate care will succeed only if the plaintiff can show that the treatment administered was so "woefully inadequate" that it amounted to "no treatment at all." *Westlake*, 537 F.2d at 860 n.5; *accord Rouster v. Cty. of Saginaw*, 749 F.3d 437, 448 (6th Cir. 2014); *Alspaugh*, 643 F.3d at 169.

Here, the inmates allege only *inadequate* care, not a total deprivation of care. Their complaint shows that the prison *did* treat them under its then-applicable protocols. For example, prison officials monitored the inmates' conditions, counseled them, and stood ready to provide antiviral medication if necessary. But according to the inmates, that was not enough. They say the officials exhibited deliberate indifference by failing to provide: (1) direct-acting antivirals "at the earliest pos[s]ible stage" of their condition; and (2) certain diagnostic tests like ultrasounds and vibration-controlled transient liver elastrography. *See, e.g.*, R.6, Compl. ¶¶21, 31, 33, 37–38, 42, PageID#243–46. Needless to say, this argument focuses on the *adequacy* of the medical care the inmates received; it has nothing to do with *whether* the inmates received care.

And the argument fails as a matter of law. They pleaded no facts that, if true, would permit a court to find that the prison's care was so bad that it was equivalent to providing no care at all. *Westlake*, 537 F.2d at 860 n.5; *accord Rouster*, 749 F.3d at 448; *Alspaugh*, 643 F.3d at 169. True, they alleged that the medical community outside prison treats hepatitis C by administering antivirals as soon as possible. But the Constitution does not require that doctors adhere to the prevailing standard of care—it forbids only deliberate indifference to prisoners' serious health concerns. The facts alleged do not state a plausible claim that the doctors who developed the protocols and treated the inmates—doctors who monitored the inmates' health, who counseled the inmates regarding ways to improve, and who stood ready to administer antiviral medications where appropriate—were indifferent to the inmates' serious medical needs.

2. Although the officers should win on the merits, this Court should at least affirm the District Court's dismissal of the *damages* claims on the basis of qualified immunity. (Qualified immunity would not entitle the defendants to dismissal of the official-capacity claims seeking injunctive relief.) Under the qualified-immunity doctrine, government officials may be held personally liable only for violations of "clearly established" rights. An official violates a "clearly established" right only if, in light of existing precedent, the illegality of his actions is "beyond

debate." *Ashcroft v. al-Kidd*, 563 U.S. 731, 741 (2011). No case from this Court or the Supreme Court of the United States establishes "beyond debate" that the Department's protocols, or the protocols' application to the inmates, violated the Eighth Amendment. To be sure, the officers did not raise this defense below, so the Court would ordinarily deem it waived. But the Court should exercise its discretion to forgive the waiver. For one thing, qualified immunity is a purely legal issue that can be adequately addressed at this stage. For another, the officers will be free to raise it on remand if this Court declines to address it, meaning failing to address this purely legal issue now would not spare the inmates from having to contend with it.

3. If the Court agrees that the inmates' deliberate-indifference claims fail, it need not go further. But even if it finds that the inmates did adequately plead a deliberate-indifference claim, it should still affirm the dismissal of the claim against Grafton's healthcare administrator, because the claim is based on a theory of *respondeat superior* liability. The sole basis for the inmates' suit against the administrator is that he is "charged with supervision and oversight of all medical personal and care … for all [of Grafton's] prisoners." R.6, Compl. ¶51, PageID#247. And liability for being "charged with overseeing a subordinate who violated the constitutional rights of another," is liability based on *respondeat superior*. *Peatross v. City*

of Memphis, 818 F.3d 233, 241 (6th Cir. 2016). The inmates argue that the bar on *respondeat superior* suits does not apply to official-capacity (as opposed to personal-capacity) suits. That is wrong. *See Goodman v. Kimbrough*, 718 F.3d 1325, 1335 (11th Cir. 2013); *Jones v. Horne*, 634 F.3d 588, 600 (D.C. Cir. 2011); *Lane v. City of Lafollette*, 490 F.3d 410, 424 n.6 (6th Cir. 2007). So the fact that the inmates are suing Grafton's healthcare administrator in his official capacity does not save the *respondeat superior* claim.

STANDARD OF REVIEW

This Court reviews *de novo* a district court's order granting a motion to dismiss for failure to state a claim. *Inge v. Rock Fin. Corp.*, 281 F.3d 613, 619 (6th Cir. 2002). "To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.*

While complaints filed by *pro se* litigants are "given liberal readings, even they must set forth a discernible federal claim." *Saylor v. Williams*, No. 86-5469, 1986 U.S. App. LEXIS 33407, at *2 (6th Cir. Nov. 10, 1986) (citations omitted).

Pro se litigants must do "more than" make "bare assertion[s] of legal conclusions." *Bartlett v. Michigan*, No. 17-2274, 2018 U.S. App. LEXIS 12221, at *4 (6th Cir. May 9, 2018). And they fail to state a claim if their complaints lack "either direct or inferential allegations respecting all the material elements to sustain a recovery under some viable legal theory." *Id.*

As "a general rule, matters outside the pleadings may not be considered in ruling on a 12(b)(6) motion to dismiss unless the motion is converted to one for summary judgment under Fed. R. Civ. P. 56." *Bash v. Textron Fin. Corp. (In re Fair Fin. Co.)*, 834 F.3d 651, 656 n.1 (6th Cir. 2016) (quotations omitted). But documents attached to the complaint qualify as part of the pleadings—and may be considered at the motion-to-dismiss stage—if they are central to the plaintiffs' claims. *Id.*; *accord Se. Tex. Inns, Inc. v. Prime Hosp. Corp.*, 462 F.3d 666, 670 n.4 (6th Cir. 2006). Courts may also "consider public records without converting a Rule 12(b)(6) motion into a Rule 56 motion." *Jones v. City of Cincinnati*, 521 F.3d 555, 562 (6th Cir. 2008).

ARGUMENT

I. This Court should affirm the judgment of the District Court.

The District Court properly dismissed the inmates' claims under Rule 12(b)(6) for failure to state a claim upon which relief can be granted. All of the in-

mates' claims against each defendant allege that the defendants (or the defendants' supervisees) violated the Eighth Amendment through deliberate indifference to the inmates' serious medical needs. But the inmates failed to allege facts that, if true, would entitle them to relief. Accordingly, the District Court properly dismissed the claims against every defendant.

Even if the Court stops short of affirming the District Court in all respects, it should affirm in part the judgment below. For one thing, it should affirm the dismissal of the claim for damages against the officials, because each official is entitled to qualified immunity. Second, the Court should affirm the dismissal of the claim against Grafton's healthcare administrator because it rests on a theory of *respondent superior*—a theory unavailable in §1983 suits like this one.

A. The District Court properly held that the inmates failed to allege a deliberate-indifference claim.

The District Court dismissed the inmates' claims, all of which rest on a theory of deliberate indifference to serious medical needs under the Eighth Amendment, under Rule 12(b)(6). This Court should affirm.

1. The Eighth Amendment forbids the government from inflicting "cruel and unusual punishments." That constraint, which applies to the States through the Fourteenth Amendment, has been interpreted to bar "prison officials from 'unnecessarily and wantonly inflicting pain' on an inmate by acting with 'deliberate

indifference' toward the inmate's serious medical needs." *Blackmore v. Kalamazoo Cty.*, 390 F.3d 890, 895 (6th Cir. 2004) (quoting *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)). Deliberate-indifference claims have "objective and subjective components." *Id.* "The objective component requires the existence of a 'sufficiently serious' medical need." *Id.* (quoting *Farmer v. Brennan*, 511 U.S. 825, 834 (1994)). "[A] medical need is objectively serious if it is 'one that has been diagnosed by a physician as mandating treatment *or* one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention.'" *Id.* at 897 (quoting *Gaudreault v. Mun. of Salem*, 923 F.2d 203, 208 (1st Cir. 1990)). The parties to this case agree that hepatitis C counts "as a serious medical need." *Hix v. Tennessee Dep't of Corr.*, 196 F. App'x 350, 356 (6th Cir. 2006) (citing *Owens v. Hutchinson*, 79 F. App'x 159, 161 (6th Cir. 2003)); R.26, MTD Reply, PageID#519.

"The subjective component requires an inmate to show that prison officials have 'a sufficiently culpable state of mind in denying medical care.'" *Blackmore*, 390 F.3d at 895 (quoting *Brown v. Bargery*, 207 F.3d 863, 867 (6th Cir. 2000)). This Court has equated that state of mind to criminal recklessness. *Santiago v. Ringle*, 734 F.3d 585, 591 (6th Cir. 2013). Thus, "[w]here a prisoner has received *some* medical attention and the dispute is over the *adequacy* of the treatment," the Court is "generally reluctant to second guess medical judgments and to constitu-

tionalize claims which sound in state tort law." *Westlake v. Lucas*, 537 F.2d 857, 860 n.5 (6th Cir. 1976) (emphasis added); *accord Graham v. Cty. of Washtenaw*, 358 F.3d 377, 385 (6th Cir. 2004). After all, officials who offer "some medical attention"—even if that attention turns out to be inadequate—are generally not criminally reckless. Nor would they generally be described as "indifferent" to the inmate's medical needs.

This Court therefore "distinguish[es] between cases where the complaint alleges a complete *denial* of medical care and those cases where the claim is that a prisoner received *inadequate* medical treatment." *Westlake*, 537 F.2d at 860 n.5 (emphasis added); *accord Rhinehart v. Scutt*, 894 F.3d 721, 740 (6th Cir. 2018); *Alspaugh v. McConnell*, 643 F.3d 162, 169 (6th Cir. 2011). In the second class of cases—those resting on allegedly inadequate care—the plaintiff's case is far more difficult. "A doctor's errors in medical judgment or other negligent behavior do not suffice to establish deliberate indifference." *Rhinehart*, 894 F.3d at 738. When "a prison doctor provides" some "treatment, albeit carelessly or inefficaciously, … he has not displayed a deliberate indifference to the prisoner's needs, but merely a degree of incompetence which does not rise to the level of a constitutional violation." *Comstock v. McCrary*, 273 F.3d 693, 703 (6th Cir. 2001). To permit such claims would be to let judges "second guess medical judgments," *Westlake*, 537 F.2d at

860 n.5, inevitably leading to "the constitutionalization of medical malpractice claims," *Comstock*, 273 F.3d at 703.

"Of course," the fact that a prisoner received *some* treatment does not completely end the case, because "in some cases the medical attention rendered may be so woefully inadequate as to amount to no treatment at all." *Westlake*, 537 F.2d at 860 n.5. But to prevail on a deliberate-indifference claim, the inmate who received care must show that the care received was "'*grossly* [] inadequate.'" *Rhinehart*, 894 F.3d at 737 (quoting *Miller v. Calhoun Cty.*, 408 F.3d 803, 819 (6th Cir. 2005)) (emphasis added). That is a high bar; one that applies only to care that is "'so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.'" *Id.* (quoting *Miller*, 408 F.3d at 819); *accord Terrance v. Northville Reg'l Psychiatric Hosp.*, 286 F.3d 834, 843 (6th Cir. 2001).

Before moving on to the application of these standards, it is important to make one clarification and one historical note. First, the clarification: some cases treat the requirement to prove "grossly inadequate" care as part of the "objective" prong of the deliberate-indifference test, not the "subjective prong." *See, e.g.*, *Rhinehart*, 894 F.3d at 737–38. But the formal question of where to situate this requirement is unimportant. What matters is this: to prevail on a deliberate-indifference claim based on inadequate treatment, plaintiffs must show that the

treatment administered was not just bad, but so inadequate that it shocks the conscience. *See id.*

Now the historical note. It is doubtful that the Eighth Amendment, as an original matter, prohibited even deliberate indifference to serious medical conditions. After all, the Eighth Amendment prohibits cruel and unusual *punishments*, and the word "punishments" most naturally connotes something carried out "as part of a sentence," not inadequate medical care during the carrying out of that sentence. *Helling v. McKinney*, 509 U.S. 25, 42 (1993) (Thomas, J., dissenting); *accord Wilkins v. Gaddy*, 559 U.S. 34, 41 (2010) (Thomas, J., concurring in the judgment). This Court is of course bound by precedents recognizing the viability of deliberate-indifference claims. But the inconsistency of those claims with the Constitution's original meaning counsels against *extending* the doctrine any further. While courts are bound by Supreme Court precedents, they "should resolve questions about the scope of those precedents in light of and in the direction of the constitutional text and constitutional history." *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 537 F.3d 667, 698 (D.C. Cir. 2008) (Kavanaugh, J., dissenting).

2. The Court need not "resolve questions about the scope of" its precedents in this case: applying the settled principles outlined above, the inmates failed to allege a plausible claim for relief under a deliberate-indifference theory.

As an initial matter, this is a case about allegedly "'inadequate medical treatment,'" not the "'complete denial of medical care.'" *Rhinehart*, 894 F.3d at 740 (quoting *Alspaugh*, 643 F.3d at 169). The inmates' pleadings confirm that each received treatment. Specifically, they show that each was enrolled in the Chronic Care Clinic, R.6., Compl., Exs. R–T, PageID#422–424, and that, through the Clinic, each was monitored to ensure that his disease did not progress to its advanced stages. *See id.*, Ex. L., PageID#380; Ex. M, PageID#381–86. As part of this monitoring, each received a bevy of counseling, vaccinations, and testing designed to slow the progression of the disease, to prevent the acquisition of new diseases, and to prevent the spread of hepatitis C to others. *See id.*, Ex. L., PageID#380; Ex. M, PageID#381–86. Moreover, if the inmates had developed certain symptoms (like portal hypertension) the inmates would have received medication (like beta blockers) regardless of how far their conditions had progressed. *See id.*, Ex. L., PageID#379–80. And if their examinations had revealed that they had begun to develop a significant amount of fibrosis, the inmates would have been administered antiviral medication, assuming they satisfied the other criteria. *See id.*, Ex. L., PageID#375.

Because the inmates received *some* care, the question whether the District Court rightly dismissed their deliberate-indifference claims turns on whether they alleged facts that, if true, would show the treatment they received was "'so grossly

incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.'" *Rhinehart*, 894 F.3d at 737 (quoting *Miller*, 408 F.3d at 819); *accord Terrance*, 286 F.3d at 843. In other words, did the inmates allege facts permitting the inference that the treatment administered was so "woefully insufficient" that it amounted to "no treatment at all"? *Westlake*, 537 F.2d at 860 n.5; *accord Rouster*, 749 F.3d at 448; *Alspaugh*, 643 F.3d at 169.

They did not. The program administered by the Clinic was hardly the conscience-shocking equivalent of no care at all. It enabled the detection and monitoring of all inmates with hepatitis C, guaranteed access to counseling and other services, and ensured medicinal treatment for those whose conditions worsened. *See* R.6, Compl., Ex. L., PageID#379–80; Ex. M, PageID#381–86. Far from displaying indifference to the inmates' needs, the officers, through the Clinic, actively engaged with them and supervised the administration of care. That is more than enough to satisfy the demands of the Eighth Amendment.

Cases from around the country come out the same way. Take, for example, *Roy v. Lawson*, 739 F. App'x 266 (5th Cir. 2018) (*per curiam*). There, the prisoner complained that he had "never been treated" for his hepatitis, and that new drugs with "a high cure rate [were] available[,] but that he ha[d] been denied access to [those] drugs." *Id.* at 266. The Fifth Circuit rejected his claims, holding that the

prisoner was not challenging the complete deprivation of care, but rather "the medical judgment exercised by prison medical staff in determining the appropriate course of his Hepatitis C treatment." *Id*. at 267. The prisoner in *Roy*, much like the inmates here, had "been seen by medical personnel regularly to monitor his condition through lab work and blood testing." *Id*. at 266. That monitoring defeated any argument that prison officials "acted with a wanton disregard for" the prisoner's "serious medical needs," and did "not give rise to a constitutional violation." *Id.* at 266–67.

Or take *Black v. Alabama Department of Corrections*, 578 F. App'x 794 (11th Cir. 2014) (*per curiam*), in which the Eleventh Circuit reached a similar conclusion. The prisoner in that case argued that the defendants had been deliberately indifferent to his serious medical needs by refusing to enroll him in the prison's "Hepatitis C Treatment Program, in which inmates are considered for antiviral drug treatment." *Id.* at 795. The prisoner did not qualify for enrollment because his "periodic liver function and liver enzyme test results were in the normal range and indicated that his condition was stable." *Id.* The court rejected the inmate's argument. In doing so, it concluded that "this [was] not a case of denied or delayed treatment." *Id.* at 796. Instead, "the record establishe[d] that" the inmate had "received treatment" in the form of "regular care and monitoring" along with

"medication for his symptoms, such as Lactulose to manage his blood ammonia levels." *See id.* at 795–96. The inmate's contention that the "defendants should have placed him in the Hepatitis C Treatment Program" constituted "a mere disagreement between an inmate and the prison's medical staff as to the course of treatment." *Id.* at 796. And that "[did] not establish deliberate indifference." *Id.*

True enough, the inmates alleged that the medical community recommends giving direct-acting antivirals "at the earliest pos[s]ible stage" of the disease, and that they should have their conditions monitored with certain diagnostic tests like ultrasounds and vibration-controlled transient liber elastography. R.6, Compl. ¶¶21, 23, 24, PageID#243; *see also id.* ¶¶31, 33, 37–38, 42, PageID#244–46. But even if those allegations are true—even if they are correct about what the medical community deems best—the Eighth Amendment does not guarantee inmates the most effective form of treatment. Nor does it mandate that prison doctors adhere to the standard of care applicable outside of prison. Rather, it guarantees inmates treatment that is not "'so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness.'" *Rhinehart*, 894 F.3d at 737 (quoting *Miller*, 408 F.3d at 819). That is why "a prison doctor [who] provides treatment, albeit carelessly or inefficaciously, to a prisoner, [] has not dis-

played a deliberate indifference to the prisoner's needs." *Comstock*, 273 F.3d at 703.

Given this incredibly high bar to proving the constitutional inadequacy of a preferred course of treatment, and given the allegations regarding the treatment the inmates received, the inmates failed to allege facts that allowed "the court to draw the reasonable inference that the" the officers are "liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). The treatment they are alleged to have provided was, at worst, ineffectual. It was not so woefully inadequate that it amounted to no treatment at all.

Though it is perhaps gilding the lily to point this out, the relief the inmates are seeking confirms the legal inadequacy of their allegations. The inmates want: (1) a declaration that the Department's hepatitis C protocols "do not conform to the standard of care generally accepted in the medical community and serve to deny adequate necessary medical care to the Plaintiffs"; (2) an injunction "requiring the defendants [] to immediately begin adequate, timely, effective and appropriate diagnostics and treatment generally accepted in the medical community"; and (3) damages. R.6, Compl. ¶¶A–C, PageID#249. In other words, the inmates are not seeking constitutionally adequate care—they are not seeking care that is merely short of "woefully inadequate." Nor could they, since they are already getting

that. Instead, they are asking the federal courts to "second guess medical judgments and to constitutionalize claims which sound in state tort law" (as medical malpractice suits) if they sound anywhere at all. *Westlake*, 537 F.2d at 860 n.5. That sort of second guessing is precisely what the "high bar that a plaintiff must clear to prove an Eighth Amendment medical-needs claim" is supposed to prevent. *Rhinehart*, 894 F.3d at 738–39.

3. In sum, even accepting as true all of the allegations in the inmates' complaint, they failed to state a plausible claim for deliberate indifference to medical need under the Eighth Amendment. Since that is the only claim they raised against the defendants in this case, the Court should affirm the District Court's judgment.

B. Even if the Court declines to affirm the District Court in all respects, it should affirm in part under the qualified-immunity doctrine and the bar on *respondeat superior* claims.

Even if the inmates had pleaded a plausible deliberate-indifference claim, it would still be appropriate to affirm the dismissal in part. *First*, all requests for damages against the officers fail as a matter of law under the qualified-immunity doctrine. *Second*, the deliberate-indifference claim against Grafton's healthcare administrator fails because it rests on a theory of *respondeat superior*.

1. At minimum, the Court should affirm the District Court's dismissal of the damages claims because those claims fail under the qualified-immunity doctrine.

As noted, the inmates sued the officials in their personal capacities, seeking $50 million in damages. Even if the Court declines to dismiss the deliberate-indifference claims outright, it should dismiss the requests for damages under the qualified-immunity doctrine. (Qualified immunity will not bar claims for injunctive relief.)

a. The qualified-immunity doctrine protects from civil damages government officials who perform discretionary functions. More precisely, it bars awarding damages in §1983 actions against officials whose conduct did "not violate *clearly established* statutory or constitutional rights." *Phillips v. Roane Cty.*, 534 F.3d 531, 538 (6th Cir. 2008) (quotations omitted) (emphasis added). A right is "clearly established" only if "any reasonable official in the defendant's shoes would have understood that he was violating it." *Kisela v. Hughes*, 138 S. Ct. 1148, 1153 (2018) (*per curiam*) (quotations omitted). This standard is satisfied only when existing precedent places "the statutory or constitutional question beyond debate." *Ashcroft v. al-Kidd*, 563 U.S. 731, 741 (2011).

Critically, "the clearly established right must be defined with specificity." *City of Escondido v. Emmons*, 139 S. Ct. 500, 503 (2019) (*per curiam*). Broad general

propositions—for example, "arresting officers may not use excessive force," or "prison officials must not exhibit deliberate indifference to inmates' medical needs"—are not specific enough to permit the conclusion that the right is clearly established. *See id.*; *Soudemire v. Mich. Dep't of Corr.*, 705 F.3d 560, 568 (6th Cir. 2013). Courts asking whether a right is clearly established must first home in on the "specific context of the case." *Soudemire*, 705 F.3d at 568 (quotations omitted). Then, they must ask whether the illegality of the challenged actions, in that context, is sufficiently obvious. The defendant officers are entitled to qualified immunity unless the illegality of the challenged action was so obvious that only a "'plainly incompetent'" officer would fail to see it. *City & Cty. of S.F. v. Sheehan*, 135 S. Ct. 1765, 1774 (2015) (quoting *al-Kidd*, 563 U.S. at 743).

Applied here, the qualified-immunity doctrine means the officers are immune from a civil damages award unless existing precedent established, "beyond debate," *al-Kidd*, 563 U.S. at 741, the unconstitutionality of treating the inmates under the challenged protocols. Did precedent clearly establish the inmates' claimed right to receive direct-acting antivirals "at the earliest pos[s]ible stage" of the disease's progression? R.6, Compl. ¶21, PageID#243. Did it clearly establish a right to be treated using diagnostic tests like ultrasounds and vibration-controlled transient liver elastrography? *Id.* ¶33, PageID#244.

No. There is no "reasonable official" who, upon being placed in the shoes of the officers, "would have understood that" he was violating the Eighth Amendment by following the protocols or declining to administer the treatment the inmates demanded. *Kisela*, 138 S. Ct. at 1153 (quotations omitted). After all, no Supreme Court case has addressed the same issues in the same context as those raised in this case. And the inmates concede in their opening brief that none of this Court's analogous precedents squarely governs this case. Op.Br.28. n.12. To the extent those cases are persuasive, nearly all of them support the officers' position. *See e.g.*, *Cook v. Corizon Health, Inc.*, No. 19-1660, 2020 U.S. App. LEXIS 5006, at *7 (6th Cir. Feb. 18, 2020) (per curiam); *Hix*, 196 F. App'x 350, 357 (6th Cir. 2006); *Edmonds v. Robbins*, 67 F. App'x 872, 873 (6th Cir. 2003).

Thus, at the very least, the officers are entitled to qualified immunity from the inmates' request for $50 million in damages.

b. The officers admittedly failed below to seek dismissal based on qualified immunity. Normally, this Court deems waived, and refuses to consider, issues not raised below. *Harris v. Klare*, 902 F.3d 630, 635–36 (6th Cir. 2018). But that rule is "not absolute." *Id.* It is "within the ambit of [this Court's] discretion to entertain questions not raised below." *Id.*

Three principles jointly support exercising that discretion to forgive the waiver here. *First*, the question whether the officers are entitled to qualified immunity is purely legal. Thus, no good will come from sending the issue back for further proceedings—this Court is just as well positioned to resolve the matter as the District Court. (The officers have not yet filed an answer, and would raise a qualified-immunity defense if made to do so.) *Second*, this Court is "free to affirm the judgment" below "on any basis supported by the record." *Angel v. Kentucky*, 314 F.3d 262, 264 (6th Cir. 2002); *accord Fears v. Morgan (In re Ohio Execution Protocol)*, 860 F.3d 881, 887 (6th Cir. 2017) (*en banc*). *Third*, the decision not to raise a qualified-immunity argument below was understandable and almost certainty harmless. It was understandable because a qualified-immunity argument would have justified dismissing only the damages claims, not the requests for injunctive relief. It was almost certainly harmless because, given the District Court's decision to dismiss *all* of the claims for failing to state a claim, it would have had no reason to address any qualified-immunity arguments.

c. Instead of leaving the officials on the hook for $50 million in damages, the Court should, at bare minimum, affirm the dismissal of the request for damages under the qualified-immunity doctrine.

2. The District Court correctly dismissed the inmates' claims against Grafton's healthcare administrator because those claims seek relief under a *respondeat superior* theory.

This leaves only the question whether the District Court correctly dismissed the deliberate-indifference claims against Dr. Eddy and Grafton's healthcare administrator on the ground that those claims rested on a theory of *respondeat superior*. If the Court holds that the inmates failed to plead a plausible deliberate-indifference claim, *see above* 20–30, it need not review the correctness of the *respondeat superior* ruling. Instead, it can simply affirm on the ground that the deliberate-indifference claims against Dr. Eddy and Grafton's healthcare administrator fail as a matter of law *regardless* of whether they rest on a *respondeat superior* theory. The inmates allege that both defendants acted with deliberate indifference toward their serious medical concerns. In other words, they sued them under the same deliberate-indifference theory advanced against the other defendants. As explained above, the inmates alleged no facts giving rise to a plausible deliberate-indifference claim; even if everything in their pleadings is true, they have not alleged facts sufficient to show that the adoption or application of the challenged protocols violated the Eighth Amendment. Since the Court can affirm on any basis supported by the record, *Fears*, 860 F.3d at 887, the failure of the deliberate-indifference claims against Dr. Eddy and Grafton's healthcare administrator moots the question

whether those claims fail for the additional reason that they rest on a *respondeat superior* theory.

But if the Court determines that the inmates plausibly alleged a deliberate-indifference claim, it must consider one other question: Did the District Court correctly dismiss the deliberate-indifference claims against Dr. Eddy and Grafton's healthcare administrator on the ground that those claims rested on a theory of *respondeat superior*?

The answer is partly yes and partly no: the District Court was correct as to Grafton's healthcare administrator, but wrong as to Dr. Eddy.

a. It is well-established that "'government officials may not be held liable for the unconstitutional conduct of their subordinates under the theory of *respondeat superior*.'" *Peatross v. City of Memphis*, 818 F.3d 233, 241 (6th Cir. 2016) (quoting *Iqbal*, 556 U.S. at 675) (alteration omitted). Put another way, a supervisor may not "be held liable simply because he or she was charged with overseeing a subordinate who violated the constitutional rights of another." *Id.* Just like other officers, supervisors must have engaged in some "active unconstitutonal behavior" before they can be held liable. *Bass v. Robinson*, 167 F.3d 1041, 1048 (6th Cir. 1999). This does not mean that a supervisor needs to have physically interacted with the injured party. *See Peatross*, 818 F.3d at 242. But at a *minimum*, the plaintiff must

show that the supervisor "implicitly authorized, approved, or knowingly acquiesced in the unconstitutional conduct of the offending officers." *Shehee v. Luttrell*, 199 F.3d 295, 300 (6th Cir. 1999) (quotations omitted). A supervisor who simply fails to "supervise, control or train the offending individual is not actionable *unless* the supervisor either encouraged the specific incident of misconduct or in some other way directly participated in it." *Id.* (quotations omitted) (emphasis added).

b. The inmates failed to plead facts that satisfy these standards with respect to Grafton's healthcare administrator. The sole basis for the inmates' suit against the administrator is that he was "charged with supervision and oversight of all medical personal and care … for all [of Grafton's] prisoners." R.6, Compl. ¶51, PageID#247. But that is the very definition of liability based on *respondeat superior*—liability for simply being "charged with overseeing a subordinate who violated the constitutional rights of another." *Peatross*, 818 F.3d at 241. The District Court thus properly dismissed the inmates' suit against Grafton's healthcare administrator.

c. The District Court erred, however, in concluding that the claims against Dr. Eddy rested solely on a theory of *respondeat superior.* To the extent the inmates allege that Dr. Eddy is responsible for the conduct of doctors who implemented his

protocols, they are indeed suing under a *respondeat superior* theory. But it appears the plaintiffs are also seeking to hold him liable for his own actions, including his "direct role in interpreting and applying" the Department's treatment protocols. R.6, Compl. ¶48, PageID#247. And the pleadings show that his signature appears on both of the protocols at issue in this case. *See* R.6, Compl., Ex.L, PageID#370; *id.*, Ex.M., PageID#381. As such, at least when the complaint is read charitably, the inmates did not seek to hold Dr. Eddy responsible *only* for the conduct of those he supervised—they sought to hold him responsible for his own conduct.

The Court should still affirm the *judgment* as to Dr. Eddy. For one thing, as noted above, the protocols Dr. Eddy signed allowed doctors to exercise their discretion in providing treatment, and so Dr. Eddy could not possibly have exercised deliberate indifference as to anyone. For another, and as already explained above, the degree of treatment called for by the protocols Dr. Eddy designed well exceeds the constitutional minimum. Thus, even assuming a prison official who merely designed a medical protocol could be sued under a deliberate-indifference theory for having done so, the claims against Dr. Eddy fail.

II. The inmates do not offer a sound reason for overturning the judgment of the District Court.

The inmates raise a slew of arguments for reversal. None succeeds.

A. The inmates did not allege a facially plausible deliberate-indifference claim.

According to the inmates, they adequately alleged a deliberate-indifference theory for a few reasons. *First*, they say they alleged that the officials, instead of providing inadequate treatment, denied them treatment altogether. *Second*, they say the officials exhibited deliberate indifference by subjecting them to a generally applicable protocol that made eligibility for antiviral medication turn on bright-line rules rather than individualized considerations. *Finally*, they say they adequately alleged a deliberate-indifference claim by accusing the officials of denying them antiviral medication because of cost concerns alone.

The Court should reject all three arguments.

1. The inmates did not allege that the officers altogether denied them treatment for hepatitis C.

a. The inmates first argue that the officers "knowingly disregarded a substantial risk of serious harm to plaintiffs when then refused to treat plaintiffs' chronic" hepatitis C. Op.Br.25. According to them, the officers did not provide *inadequate* care, but rather provided no care at all—they "deliberately chose[] not to treat" the inmates' hepatitis C. Op.Br.29–30.

The problem with this argument is that it contradicts the complaint. The inmates did not allege that the officers *refused to treat* their hepatitis C. Instead,

they alleged that the officers refused to provide them one *type* of treatment—direct-acting-antiviral medication. The inmates' own pleadings show that each inmate began treatment (at the latest) upon receiving his initial evaluation in the Chronic Care Clinic. Starting at that point (at the latest), each inmate was periodically reviewed by the Clinic. *See, e.g.*, R.6, Compl., Ex. L, PageID#379–80. Over the course of these evaluations, the inmates have had access to healthcare providers, received counseling, been physically examined, had their entire medical history reviewed, and undergone a variety of diagnostic testing, including cardiac, lung, skin, neurological, and blood testing. *Id.* Thus, as the District Court recognized, the inmates alleged not that "Defendants have ignored their condition," but rather that they "disagree[d] with the course of treatment." R.52, Order, PageID#680.

All of this means that the inmates' allegations rest on a theory of constitutionally *inadequate* treatment; they do not allege the complete *deprivation* of care. *See above* 24–30. As a result, the inmates can prevail only by meeting the very high burden of showing that the care they received was conscious shocking—so grossly inadequate that it amounted to "no treatment at all." *Westlake*, 537 F.2d at 860 n.5. The facts alleged do not establish that the protocols implemented so inadequate a method of treatment. *See above* 24–30. That is presumably why the in-

mates go to such great lengths to avoid admitting that this is a case about the adequacy of care, not the deprivation of care.

b. The inmates try to make this a case about the deprivation of treatment by narrowly defining the concept of "treatment." In particular, they argue that the "monitoring" they had been receiving in the Clinic "[did] not equal 'treatment' or 'ongoing care.'" Op.Br.39. The inmates try to justify this narrow conception by pointing to the Department's protocols, which distinguished between a "course of treatment" and "monitoring." *Id.* Specifically, the inmates cite a part of the protocol that describes how the administration of antiviral therapy is supposed to proceed. R.6, Compl., Ex. L, PageID#376. That part of the protocol is labeled "Treatment." *Id.* In contrast, the next section is labeled "Monitoring," and describes the procedures that health professionals must follow in monitoring any inmate who receives antiviral therapy. *Id.*, PageID#377. This, the inmates suggest, proves that monitoring is not treatment.

This argument fails because the Department's definition of "treatment" is irrelevant. The Eighth Amendment forbids officials from denying treatment for serious medical conditions. "Treatment," in this context, means a method of caring for a medical condition. The Department's counseling and monitoring services were part of a course of care, and thus constituted "treatment," for constitutional

purposes, without regard to what the Department chose to name these services. Indeed, several decisions of this court confirm that monitoring and testing qualify as treatment for constitutional purposes. *See, e.g.*, *Cook*, 2020 U.S. App. LEXIS 5006, at *7; *Edmonds*, 67 F. App'x at 873. So does common parlance. Consider someone with a knee injury, whose doctor advises rest and continued monitoring rather than immediate surgery. Everyone would agree that person is being "treated," even if they might disagree about the wisdom of the treatment administered.

Courts around the country, including the Fifth and Eleventh Circuit cases discussed above, have interpreted comparable challenges as resting on the supposed inadequacy of care, not the deprivation of care. *See e.g.*, *Roy*, 739 F. App'x 266; *Black*, 578 F. App'x 794; *Dawson v. Archambeau*, 763 F. App'x 667, 672 (10th Cir. 2019); *Buchanon v. Mohr*, No. 2:16-cv-279, 2016 U.S. Dist. LEXIS 121432, at *7 (S.D. Ohio Sep. 8, 2016) (report and recommendation later adopted); *Williams v. Catoe*, No. 6:17cv627, 2018 U.S. Dist. LEXIS 229924, at *21–22 (E.D. Tex. Aug. 4, 2018).

True, the inmates cite a handful of cases that they say support their characterizing the treatment they received as the complete denial of treatment. But none of those cases changes the analysis. In *Gordon v. Schilling*, 937 F.3d 348 (4th Cir. 2019), the Fourth Circuit considered the claims of an inmate with hepatitis C who,

because he was parole eligible, was "categorically excluded" from receiving medicinal treatment—apparently without regard to his health condition or the prison doctors' medical judgment. *Id.* at 352, 358, 360 n.15. He instead received "a physical examination and liver function tests twice each year." *Id.* at 352. The court noted that this protocol altogether denied inmates treatment. *Id.* at 359 n.14. But it considered the issue only in passing, failing to engage with it in any depth. *Id.* Instead, it focused primarily on whether the defendants were personally involved in the inmate's care. *See id.* at 357–62. Regardless, the Fourth Circuit erred in suggesting that monitoring does not qualify as treatment. *See above* 39–41. (Indeed, monitoring may be the *better* course of treatment: since the virus can develop an immunity to drugs if the course of treatment is not completed, it can be wise to withhold drugs from an inmate who may be unable to complete treatment. *Gordon*, 937 F.3d at 355.) Anyway, even if it were true that inmates "categorically excluded" from *ever* receiving antiviral medication are denied treatment, *id.* at 352, 358, 360 n.15, that would have no bearing on this case. After all, none of the plaintiff inmates alleges that *he* was categorically excluded from receiving antiviral medications without regard to his monitoring results, and the pleadings make clear that doctors could deviate from the protocols as appropriate in their medical judgment. *Contra id.*, at 352, 358, 360 n.15; *see above* 9–10.

That leaves a handful of unpublished district court opinions. Each draws the same invalid distinction the inmates do between "monitoring" on the one hand and "treatment" with antiviral therapy on the other. *See, e.g.*, *Lovelace v. Clarke*, No. 2:19cv75, 2019 U.S. Dist. LEXIS 133012, at *12 (E.D. Va. Aug. 7, 2019); *Postawko v. Mo. Dep't of Corr.*, No. 2:16-cv-04219-NKL, 2017 U.S. Dist. LEXIS 71715, at *28 (W.D. Mo. May 11, 2017); *Abu-Jamal v. Wetzel*, No. 3:16-CV-2000, 2017 U.S. Dist. LEXIS 368, at *51 (M.D. Pa. Jan. 3, 2017). These cases say that officials who administer a "monitoring policy" *deny treatment* to inmates because monitoring is "less efficacious" than treatment with antiviral therapy. *Postawko*, No. 2017 U.S. Dist. LEXIS 71715, at *28 (quotations omitted); *accord Abu-Jamal*, 2017 U.S. Dist. LEXIS 368, at *51 (M.D. Pa. Jan. 3, 2017). That reasoning is faulty. The fact that one form of treatment is "less efficacious" than another does not mean it fails to qualify as treatment altogether, or that it is "'so grossly … inadequate … as to shock the conscience or to be intolerable to fundamental fairness.'" *Rhinehart*, 894 F.3d at 737 (quoting *Miller*, 408 F.3d at 819); *accord Terrance*, 286 F.3d at 843. And the fact that a few district courts have said otherwise ought not change anything.

Indeed, these district court cases effectively ignore the legal question (whether the care administered was so grossly inadequate as to be conscious shocking) in favor of a medical question (whether one form of care is superior, and by

how much). The inmates' *amici* make the same mistake. *See* Br. of *Amici Curiae* Drs. Joseph Bick, et al., Doc. 22. The district courts and the *amici* detail how the American Association for the Study of Liver Diseases (AASLD) or similar organizations "updated the [medical] standard of care to recommend treating *all* persons with chronic [Hepaitis] with DAA drugs," without regard to APRI scores, and without delay. *Postawko*, 2017 U.S. Dist. LEXIS 71715, at *6-7; *see also Abu-Jamal*, 2017 U.S. Dist. LEXIS 368, at *9; *Lovelace*, 2019 U.S. Dist. LEXIS 133012, at *3 n.1; Br. of *Amici* 11–21. And each concludes that any significant deviation from that standard constitutes deliberate indifference in violation of the Eighth Amendment. That simply does not follow. There is no basis for concluding that the Eighth Amendment incorporates, and binds prison officials to follow, whatever standard of care or best practices the medical community requires of itself.

c. In sum, the inmates' primary argument is that the officials, rather than providing merely inadequate care, completely deprived them of any care at all. That argument contradicts the inmates' own complaint. And as soon as one views this as a case about the adequacy of care, rather than a case about whether the prison provided any care at all, the inmates' arguments for reversal collapse.

2. The Department's treatment protocols were not "blanket policies" that failed to consider individual circumstances.

The inmates next argue that the officers' application of the policy constituted deliberate indifference in another way. The inmates say the officers denied them antiviral therapy through a rote application of a "blanket policy applied in lieu of individualized medical determinations." Op.Br.30; *accord* R.6, Compl. ¶45, PageID#246. This, they say, is unconstitutional. The inmates' argument fails for two reasons, one relating to the pleadings and the other doctrinal.

First, the pleadings issue. The inmates' argument assumes that the officers denied them antiviral therapy under a blanket policy that categorically denies treatment without undertaking an individualized analysis. But the inmates' own pleadings show that the protocols *did* include an individualized analysis. *See above* 6–10. As an initial matter, the protocols' application to any given inmate depended on facts specific to that inmate—his APRI score, for example. More fundamentally, those administering the protocols could deviate from the guidelines when it was necessary in their medical judgment. *See* R.6, Compl., Ex. L., PageID#370. Thus, even if the Constitution entitled every inmate to an individualized analysis of the best method of treating his significant health concerns, the pleadings here confirm that the challenged protocols pass muster.

The legal flaw is even more fundamental: there is no right to an individualized medical determination. Again, to prevail on the merits, the inmates would have to show that the treatment they received was "so grossly incompetent, inadequate or excessive as to shock the conscience or to be intolerable to fundamental fairness." *Terrance*, 286 F.3d at 843 (quotations omitted). That test does not prohibit the use of "blanket policies"—a term the inmates never define, but that apparently includes any policy that uses bright-line rules for deciding which inmates get a particular course of treatment. Instead, it forbids only those blanket policies that lead to grossly incompetent care. And as already explained, the inmates did not allege facts that, if true, would show that the protocols were so "woefully inadequate" that they amounted to "no treatment at all," *Westlake*, 537 F.2d at 860 n.5, either in general or as applied to the plaintiffs.

The inmates try to support their contrary argument with four cases, but none is up to the task. The first case, *De'Lonta v. Angelone*, 330 F.3d 630 (4th Cir. 2003), found deliberate indifference based on the government's inability to offer a "justification" for its policy. *Id.* at 634. Nothing in the opinion speaks to the question whether all treatment decisions must be individualized.

In the second case, *Colwell v. Bannister*, 763 F.3d 1060 (9th Cir. 2014), the Ninth Circuit considered a policy under which prisoners with one working eye

were ineligible for cataract surgery. *Id.* at 1063. The court held the policy unconstitutional because "the blanket, categorical denial of … surgery solely on the basis of an administrative policy that 'one eye is good enough for prison inmates' is the paradigm of deliberate indifference." *Id.* But the court never cast doubt on the legality of blanket denials generally—it simply held that *this* blanket denial violated the Eighth Amendment.

Similarly, *Roe v. Elyea*, 631 F.3d 843 (7th Cir. 2011), invalidated a treatment protocol on grounds having nothing to do with the protocol's blanket nature. Rather, the court invalidated the protocol because it considered "administrative convenience" "to the exclusion of reasonable medical judgment about inmate health." *Id.* at 863. That hardly creates a right to an individualized assessment disconnected from any generally applicable policy.

Last but not least, in *French v. Daviess Cty.*, 376 F. App'x 519 (6th Cir. 2010), this Court specifically found there was no "blanket policy," and thus had no occasion to consider whether policies that use bright-line rules to decide which inmates are eligible for particular treatments are *per se* unconstitutional. *Id.* at 523.

*

In sum, this Court should reject the inmates' arguments against blanket policies, both because the protocols here were not "blanket policies" (in the sense of

forbidding individualized assessments) and because the protocols would be constitutional regardless.

3. The officers did not delay providing antiviral medication to the inmates for non-medical reasons.

Next, the inmates argue that the officers unlawfully delayed or deny treatment based "not on [a] medical rationale but on the cost of treatment." Op.Br.33. But the flaw in this argument is the same one that appears again and again: the officers never delayed or denied the inmates treatment. To the contrary, the complaint and its exhibits showed that *all* Ohio prisoners were tested for hepatitis C, and that *all* were entered into the treatment program immediately upon being diagnosed. *See* R.6, Ex. L, PageID#373–74. True, the officers declined to give the inmates the precise treatment they wanted at the precise time they wanted it. But that does not mean the officers delayed or denied treatment—it means the officers delayed or denied the precise treatment the inmates wanted.

In any event, while prisons cannot base treatment decisions on costs *alone*, they may consider costs without violating the Eighth Amendment. *Darrah v. Krisher*, 865 F.3d 361, 372 (6th Cir. 2017). Necessarily so: in a world with scarce resources (like ours) prison officials must decide how best to allocate the resources available for inmates' medical care. The question, then, is not whether the cost of medication played some role in the officers' decisions. It is whether cost played the

only role in motivating the officers' decision. And while the inmates allege they were denied medication "based solely upon cost," R.6, Compl. ¶45, PageID#246, the allegation is not plausible. The inmates' own pleadings show that the inmates were denied antiviral therapy under the protocols because none of their conditions had progressed to the later stages of the disease. *See* R.6, Exs. R–T, PageID#422–424. That delay was *medically* justifiable because "Hepatitis C is a *slowly* progressive viral condition" that causes "long-term complications" only "in a limited number of patients." *Id.*, Compl., Ex. L, PageID#371 (emphasis added). And even for those "who do develop advanced disease, this process occurs over ten to twenty years or longer." *Id.*

Undeniably, cost-constraints played some role in the formulation of the protocols. How could it not? There is neither an infinite supply of any given treatment nor an infinite amount of money with which to purchase such treatments. It is thus impossible to give all patients—whether they are in prison or not—precisely the care they want at precisely the time they want it. Still, the pleadings in this case confirm that the challenged protocols made eligibility for treatment turn on the patient's medical condition and the prospects of successful treatment, *see* R.6, Compl., Ex. L, PageID#374, not the cost of treating him. And the pleadings flat out

contradict the suggestion that, with respect to any inmate, the prison denied care *solely* because of cost.

Allah v. Thomas, 679 F. App'x 216 (3d Cir. 2017) (*per curiam*) (cited in Op.Br.19, 28, 33), is not to the contrary. That case reversed the dismissal of a deliberate-indifference claim brought by a prisoner with hepatitis C, who alleged "that he did not receive *any* treatment for his Hepatitis C condition." *Id.* at 220. It is unclear from the opinion whether the plaintiff alleged he was monitored, counseled, tested or otherwise had his health concerns addressed. Thus, it appears to be a case about the complete denial of care, not a case (like this one) alleging mere inadequacy of care. Second, the plaintiff there alleged that the prison refused to treat him "*solely* because it was cost-prohibitive." *Id.* The inmates here failed plausibly to make such an allegation; their own pleadings confirm that they *did* receive treatment (in the form of monitoring, examinations, and so on) and that no treatment decisions were based *exclusively* on cost. To the extent *Allah* suggests that pleadings like that could survive a motion to dismiss, it erred.

Because the inmates' pleadings refute the inmates' argument that the officers made treatment decisions based entirely on cost, the Court should reject this argument along with the others.

B. The District Court properly dismissed the claims against the Grafton healthcare administrator

Lastly, the inmates challenge the District Court's analysis of the claims against Grafton's healthcare administrator and Dr. Eddy.

The inmates apparently concede that their claims against Grafton's healthcare administrator rest on a *respondeat superior* theory. Op.Br.40–44. But that poses no problem, they say, because they sued the healthcare administrator in his *official* capacity and the bar on *respondeat superior* claims applies only to *individual*-capacity claims. *Id.*

In fact, the *respondeat superior* theory is equally unavailable in personal- and official-capacity suits. *See Goodman v. Kimbrough*, 718 F.3d 1325, 1335 (11th Cir. 2013); *Jones v. Horne*, 634 F.3d 588, 600 (D.C. Cir. 2011); *Lane v. City of Lafollette*, 490 F.3d 410, 424 n.6 (6th Cir. 2007). That is hardly a surprise. Official-capacity and personal-capacity suits both rest on §1983. The statute's text does not change between one and the other. Neither, therefore, should the availability of relief under a *respondeat superior* theory.

The inmates also argue that the claims against Dr. Eddy do not rest exclusively on a *respondeat superior* theory. The officers agree. *See above* 37–38. Nonetheless, the Court should affirm the judgment against Dr. Eddy because the in-

mates have not alleged facts giving rise to a plausible deliberate-indifference claim against him or anyone else. *See above* 37–38.

CONCLUSION

The Court should affirm the District Court's judgment.

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CERTIFICATE OF COMPLIANCE

I hereby certify, in accordance with Rule 32(g) of the Federal Rules of Appellate Procedure, that this motion complies with the type-volume for a principal brief and contains 11,554 words. See Fed. R. App. P. 32(a)(7)(B)(i).

I further certify that this brief complies with the typeface requirements of Federal Rule 32(a)(5) and the type-style requirements of Federal Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Equity font.

/s/ Benjamin M. Flowers
BENJAMIN M. FLOWERS

CERTIFICATE OF SERVICE

I hereby certify that on this April 3, this brief was filed electronically. Notice of this filing will be sent to all parties for whom counsel has entered an appearance by operation of the Court's electronic filing system. Parties may access this filing through the Court's system.

/s/ Benjamin M. Flowers
BENJAMIN M. FLOWERS

DESIGNATION OF DISTRICT COURT RECORD

Defendants-Appellees, pursuant to Sixth Circuit Rule 30(g), designates the following filings from the district court's electronic records:

***Mann v. Ohio Department of Rehabilitation and Correction*, 2:18-cv-01565**

Date Filed	R. No.; PageID#	Document Description
12/11/2018	R.6; 239–49, 361, 370–86, 412, 422–25	Complaint
2/20/2019	R.15; 454	State of Ohio's Motion to Dismiss
3/6/2019	R.20; 483	Ohio Department of Rehabilitation and Correction's Motion to Dismiss
4/2/2019	R.26; 519	Ohio Department of Rehabilitation and Correction's Reply to Plaintiff's Response to Motion to Dismiss
6/26/2019	R.45; 632	Report and Recommendation
7/24/2019	R.52; 667–81	Order Adopting Report and Recommendation
7/25/2019	R.53	Judgment
8/26/2019	R.56; 696–701	Report and Recommendation
9/26/2019	R.58; 709	Order Adopting Report and Recommendation
9/26/2019	R.59	Judgment
10/24/2019	R.60	Notice of Appeal